Editor's key points

- The effects of trauma on the lives and health of women remain inadequately addressed by mainstream medicine. It is essential to develop an approach to patients with a history of trauma. A trauma-informed approach makes care accessible to survivors of trauma while adapting to their unique vulnerabilities and health challenges.
- The primary care experiences reported by the women in this study highlighted some of the principles of trauma-informed care: their physicians seeing them as a whole person and building a relationship (safety and trustworthiness principle); the patient being involved in her care and decision making (choice, control, and collaboration principle); and although physicians did not ask about patients' history of trauma, patients themselves recognized that their adverse childhood experiences were important to their health and believed that their health care providers should be aware of their past (trauma awareness and acknowledgment principle).
- The authors suggest that trauma-informed care needs to be more prevalent in primary care. Health professionals need the proper education and tools to address the complexity of managing survivors of traumatic experiences. Most women in this study stated that discussing their history of trauma did not trigger any feelings of distress; however, events such as Papanicolaou tests and some physical examination maneuvers did.

Primary care experiences of women with a history of childhood trauma and chronic disease

Trauma-informed care approach

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Abstract

Objective To understand the primary care experiences of women who have a history of childhood trauma and chronic disease.

Design Qualitative study using in-depth interviews with directed content analysis.

Setting Family health team in Kingston, Ont.

Participants Twenty-six women.

Methods Letters of invitation were sent to eligible participants followed by a telephone survey. Women with an adverse childhood experience (ACE) score of 4 or higher and with 2 or more chronic conditions were invited to participate in a one-on-one interview.

Main findings Participants were frequent users of health care services. Most had not been asked about ACEs by their family physicians. Most participants believed that their history of ACEs was important to their health and that providers should ask about childhood experiences. When participants discussed their primary care experiences, the following 6 common themes evolved: the importance of continuity of care; challenges with family medicine residents; provider awareness of abuse history; distress due to triggering events; characteristics of clinic staff and space; and engagement in care plans and choice. These discussions revealed that participants' primary care experiences were not always informed by the principles of trauma-informed care.

Conclusion Understanding the effect of ACEs on women's health is important. Incorporating a trauma-informed approach can be beneficial and enhance the experience of patients. Physicians should learn to ask patients about their childhood experiences, as it is important to their health care.

Expériences vécues dans les soins primaires par des femmes ayant des antécédents de traumatismes durant l'enfance et de maladies chroniques

Approche des soins tenant compte de ces antécédents

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Résumé

Objectif Comprendre les expériences que vivent, en milieu de soins primaires, les femmes ayant des antécédents de traumatismes dans l'enfance et de maladies chroniques.

Type d'étude Étude qualitative à l'aide d'entrevues en profondeur, suivie d'une analyse de contenu dirigée.

Contexte Une équipe de santé familiale de Kingston, en Ontario.

Participantes Trente-six femmes.

Méthodes On a lancé des invitations à des femmes admissibles, puis on a procédé à un sondage téléphonique. Les femmes dont le score relatif aux expériences négatives durant l'enfance (ENE) s'élevait à au moins 4 et à au moins 2 pour des maladies chroniques ont été invitées à participer à une entrevue individuelle.

Principales observations Les participantes utilisaient souvent les services de santé. La plupart n'avaient jamais été questionnées par leur médecin de famille au sujet des ENE. La plupart des participantes croyaient que leurs antécédents d'ENE étaient importants pour leur état de santé et que leur soignant devrait s'informer de de type d'antécédent. De leur discussion sur les soins primaires reçus, on a retenu les 6 thèmes communs suivants : l'importance de la continuité des soins; les défis associés aux résidents en médecine familiale; la connaissance des ENE par le soignant; la détresse causée par les événements déclencheurs; les caractéristiques du lieu et du personnel de la clinique; et l'intention de changer la façon de prodiguer des soins à ce type de patientes. Ces discussions ont aussi fait ressortir le fait que l'expérience des soins primaires vécue par les participantes n'était pas toujours conforme aux principes qui devraient régir des soins tenant compte des antécédents de traumatismes.

Conclusion Il est important de tenir compte des effets des ENE sur la santé des femmes. Une telle approche peut être avantageuse et améliorer la satisfaction des patientes. Les médecins devraient apprendre à s'informer des expériences vécues par leurs patientes durant l'enfance puisque c'est important pour leurs soins de santé.

Points de repère du rédacteur

- La médecine traditionnelle ne s'est pas suffisamment intéressée aux effets des traumatismes sur la vie et la santé des femmes. Il est essentiel de développer une façon de traiter ces patientes. Une approche tenant compte de ces antécédents rend les soins plus accessibles aux survivantes de traumatismes tout en s'adaptant à leurs vulnérabilités et à leurs problèmes de santé.
- Les expériences que les femmes participantes à cette étude ont dit avoir vécues dans les soins primaires ont mis en lumière certains des principes des soins tenant compte des traumatismes : leurs médecins les considéraient comme des personnes entières et établissaient une bonne relation (principe de la sécurité et de la confiance); la patiente participait au traitement et aux décisions (principe du choix, du contrôle et de la collaboration); et, bien que les médecins ne leur aient pas demandé si elle avaient été victimes de traumatisme, les patientes affirmaient spontanément que les expériences négatives de leur enfance avaient beaucoup d'importance pour leur santé et qu'elles croyaient que leurs soignants devraient avoir connaissance de leur passé (connaissance des traumatismes et principe de la reconnaissance).
- Les auteurs croient qu'il est nécessaire de tenir davantage compte des antécédents de traumatismes dans les soins primaires. Les professionnels de la santé ont besoin d'une formation adéquate et d'outils pour faire face à la complexité d'une gestion adéquate de ces cas de traumatisme. Dans cette étude, les femmes ont déclaré que le fait de discuter de leurs antécédents traumatiques n'avait pas provoqué de sensation de détresse : toutefois, certaines manœuvres, comme un test de Papanicolaou ou un examen physique, pouvaient avoir cet effet.

There is growing awareness of the important association between a person's history of traumatic events and their overall health. In the sentinel Adverse Childhood Experiences (ACE) Study,[1] a cohort of more than 17 000 middle-class individuals from a health maintenance organization in California completed the ACE questionnaire tool, which surveyed the prevalence of ACEs. In this cohort, the rate of childhood sexual abuse in women was 28%, with 17% of all participants experiencing 4 or more ACEs and only 34% reporting no ACEs.[1] The ACE study and the subsequent years of follow-up, including more than 60 articles based on the original study, demonstrate the positive association between an increasing ACE score and incidence of multiple mental and physical illnesses. An ACE score of 4 or more is associated with increased rates of multiple chronic mental and physical health issues. Given the high degree of association and the emerging understanding of pathophysiologic mechanisms, this relationship is believed to be causative.[2] Whereas the original ACE study documented increases in psychiatric conditions, addictions, and risky sexual behaviour,[1] subsequent analysis reveals strong associations with many medical diseases such as cardiovascular disease, respiratory disease, and cancer.[1] In people with a high burden of ACEs, increased rates of disease are independent of traditional risk factors such as smoking and obesity.[1-3]

Despite extensive awareness and more than 100 years of documentation,[4] the effects of trauma on the lives and health of women remain inadequately addressed by mainstream medicine.[5] Trauma-informed care is an approach that incorporates an understanding of the unique consequences of a history of trauma. This care is not trauma focused, as it does not seek to address the specific issues of an individual's trauma history. This approach seeks to make care accessible to survivors of trauma while adapting to their unique vulnerabilities and health challenges. Trauma-informed care is based on principles that integrate the concepts of trauma recognition; physical and emotional safety and trustworthiness; decision making and collaborative relationships with providers; empowerment; and cultural and gender needs.[6,7] We provide a more in-depth discussion about these principles in a commentary in this issue of *Canadian Family Physician* (**page 170**).[8] The objective of this study was to understand the primary care experiences of women with a history of childhood trauma and chronic disease. Recognizing the documented link between ACEs and chronic disease, this study explored the structures, behaviour, and characteristics of the primary health care system that affect one's care.

Methods

Study design

A qualitative research approach with directed content analysis was used. Such approaches have been widely used in the health sciences.[9] One-on-one, in-depth, semistructured interviews were used to assess health care experiences from the perspective of women with 2 or more diagnosed non-psychiatric conditions and an ACE score[10] of 4 or higher.

Ethics approval was obtained from Queen's University Research Ethics Board.

Participants

Participants were recruited from an academic family health team in Kingston, Ont, using electronic medical records. A list was compiled of women aged 21 or older with 2 or more non-psychiatric diagnoses as recorded in ICD-9 codes in their electronic medical records. A list of potential participants was provided to the most responsible physician (MRP) who was then able to exclude patients. Reasons for exclusion included death, having moved away, or any other patients that MRPs did not wish to invite to participate in the study. Eligible participants (N=457) were sent a letter signed by their MRP explaining the study and requesting participation. Participants self-selected and called a predesignated telephone number where a researcher explained the study, obtained consent, and administered the ACE questionnaire (available at **CFPlus***) over the telephone. Those women with an ACE score of 4 or higher were invited to participate in a one-on-one, in-person interview.

Data collection

Information on participants' demographic characteristics was collected at the time of the interview. In-depth interviews lasting approximately 60 minutes were conducted by 1 of 2 investigators, who were both trained trauma therapists (F.M., T.B.), using a 29-item qualitative interview script (available at **CFPlus***) developed for this study by the research team. Participants were given the opportunity to expand on their answers and to add comments. Twenty-six in-depth interviews were completed and the criteria for saturation were met in that no new themes were felt to be emerging, and themes were repeating themselves. While both interviewers were trained trauma therapists, the structure of the interview script allowed for consistency of administration, and interviewers did not deviate from the script and did not engage in any therapeutic discussions with participants. The interviewers' experience was thought to be beneficial in the event of any potential triggering (although none occurred), given their heightened ability to monitor participants' reactions to questions. Participants received information on trauma resources and were called a week later and offered counseling resources if needed.

*The adverse childhood experiences questionnaire tool and the interview script are available at **www.cfp.ca**. Go to the full text of the article online and click on the **CFPlus** tab.

Data analysis

Our analysis was informed by a directed content analysis technique.[9] Directed content analysis can be used when there is existing theory about a phenomenon, but this theory is incomplete. In this case, there is a good deal of existing theory about trauma-informed care in some areas (particularly addictions and mental health); however, very little research has looked at trauma-informed care in family medicine. Interviews were audiorecorded and transcribed verbatim. Transcripts were independently reviewed in their entirety, analyzed, and coded using thematic analysis by 2 co-investigators (R.P., E.P.), both family physicians working with equity-seeking populations, who then compared and reviewed data to ensure validity of findings. NVivo 10 software was used for data management. Once coded, the themes identified were superimposed on an existing trauma-informed framework using a deductive analysis approach.[11]

Findings

Forty-three potential participants contacted the research assistant. Thirty women (70%) had an ACE score of 4 or higher and were eligible to participate; 26 participants completed the interview, and 4 participants failed to attend their scheduled interview. Participants' average ACE score was 7.2 (maximum possible score is 10). The average number of non-psychiatric medical conditions was 4.9 (**Table 1**).

Participants were high users of health care services. They reported having accessed the clinic an average of 12 times in the past year.

Interview data analysis provided a rich understanding of participants' experiences with primary care. Participants consistently articulated the importance of their primary care provider being aware of their history of ACEs.

Themes

From participants' descriptions of their primary care experiences, the following 6 themes emerged.

Importance of continuity of care. The importance of continuity of care in creating an atmosphere of safety was a common theme for participants. As one participant explained, "Having been going there for over 20 years they know me and it's always, 'Hi,' you know, 'how are the boys?' And you feel really connected with them on a different level than just a patient" (Subject 41). The relationship between the provider and patient emerged as an important element. Participants who believed that they had physicians who knew them as individuals identified themselves as being more comfortable with their care, more trusting that their care would be adequate (even in the context of care provided by a resident physician), and more forgiving if physicians appeared rushed or inattentive on a given day: "Oh, that could be a resident. My doctor's office works closely with Queen's [University] so it could be a resident but he oversees everything and I trust him" (Subject 19). Participants articulated the importance of feeling understood as a whole person and having a doctor who appeared to be invested in a long-term relationship:

> [We would talk] about everything, and he would talk to me and say, 'What's going on?' Because you know when I first went in to him he'd take my blood pressure and it'd be like 170/200 or so. I had bad kids. And he'd say, 'OK, something's going on. Tell me.' And we'd sit down there and talk. And, ah, you know, he'd do all the other stuff I was there for, but he understood where I was coming from. (Subject 2)

Challenges with family medicine residents. The challenges of interacting with resident physicians were expressed by many women. Participants perceived themselves as practice patients for residents, a position which was either understood and occasionally appreciated, or resented.

> Now I understand they have to learn. They can't just—you know—they have to learn on people. But I said I wished you would have tried on someone else instead of me! (Subject 2)

> But some of them are awesome—they treated you like an equal, on the same level and they were willing to have a discussion about it with you, which I found amazing. It was really rewarding I think for both of us. (Subject 14)

Some expressed frustration at having to repeat their story to a new person. Overall, participants appeared empathic toward residents who might have struggled with their encounters and some comments were somewhat maternal.

Provider awareness of abuse history. Most participants reported that their family physician had never asked about their childhood experiences. However, participants conveyed a clear and consistent message that asking about abuse is acceptable and appropriate.

> I think that has a lot to do with the person you grow up to be and I think they should ask .... I mean, not a 3-hour conversation because they're busy, right? But they should know that you've had a hard childhood and married life and stuff like that. (Subject 2)

> I think [that family physicians should ask about abuse] because I think it is like baggage. It's part of who I am today and when things like this happen, falling through the cracks, I might be less threatened, but I'm not going to be the best I can be optimally—health wise. (Subject 29)

Many women articulated that asking about a history of trauma was important. Participants recognized barriers to asking about abuse including time constraints and the lack of a consistent provider (in the context of an academic setting), and they also perceived a lack of training on the part of physicians. Some patients thought that their family physician would not be able to cope if they were to explain what had actually happened to them. Many patients thought that their doctor was too busy and had no time for such an in-depth conversation. Other patients assumed that their physician was aware of their history, as the physician had referred them to psychiatry, social work, or counseling services where they had divulged their trauma history.

Table 1. Participant characteristics: *N* = 26.

CHARACTERISTICS	VALUE*
Place of birth, %	
• Canada	84.6
• Other or no response	15.4
Religion, %	
• None identified or agnostic	42.3
• Christian or Catholic	42.3
• Other	15.4
Marital status, %	
• Single	11.5
• Common law or married	46.2
• Divorced or separated	42.3
No. of children, %	
• 0	19.2
• 1-3	69.2
• >3	11.5
Education level, %	
• Some high school	7.7
• High school diploma	23.1
• Trade or diploma program	15.4
• College degree	30.8
• Undergraduate university degree	15.4
• Graduate university degree	7.7
Employment, %	
• Full time	19.2
• Part time	19.2
• Unemployed	15.4
• On ODSP or other disability	38.5
• Retired	19.2
Annual income, %	
• <$20 000	46.2
• $20 000-$40 000	15.4
• $40 000-$60 000	3.8
• $60 000-$80 000	11.5
• ≥$80 000	15.4
• Do not know or do not wish to answer	7.7
Health insurance, %	
• No	19.2
• Yes, ODB	34.6
• Yes, private	42.3
• No response	3.8
Living situation, %	
• Alone	38.5
• With others	61.5
• Housing adequate for my needs	84.6
• Housing not adequate for my needs	15.4
Mean (range) no. of chronic medical conditions excluding mental health	4.9 (2-19)
ACE score, n	
• 5	4
• 6	4
• 7	6
• 8	8
• 9	3
• 10	1

ACE—adverse childhood experience, ODB—Ontario Drug Benefit, ODSP—Ontario Disability Support Program.
*Percentages might not add to 100 owing to rounding or because participants were allowed to select more than 1 answer.

Distress due to triggering events. Patients with a history of trauma can often experience anxiety or emotional distress from "triggering events." These events or triggers might not be frightening in and of themselves but can be indirectly reminiscent of past trauma. Participants did not report that discussing their trauma triggered distress. Many participants explained that triggering events can include Papanicolaou tests, some physical examination maneuvers, unexpected physical contact, and physical examinations by male residents or physicians. One patient felt that "Anything physical. Anything to do with touching" (Subject 28) could be upsetting or triggering.

More important, any health care situation in which they perceived the physician to have a patronizing or condescending manner could potentially trigger distress. This feeling of being dismissed appeared to be a common experience for many participants, particularly when they described being seen by other specialists or in the emergency department:

> Because I, I can remember saying in my mind—this is not important, this is not important, this is not important, just, just get through it. Because they were, ah—sort of—figures of authority. And I thought, you know, I'm in a curtained room in the [emergency department] and I'm thinking—where can I go from here? I can't say anything too loud. (Subject 12)

Many participants who used controlled substances described the repeated negotiations of their prescriptions as a source of anxiety and distress.

Characteristics of clinic staff and space. Many of the clinic's features were welcoming, particularly front-desk staff and nurses. The staff members were respectful and were perceived by participants as advocates. Most participants described the waiting room and office areas as comfortable. Some participants did not like waiting alone in small enclosed examination rooms. Several participants identified that they did not like that the chairs in the waiting room were close together, as they did not like to sit close to other people, men in particular:

> Well, I don't like the fact that the chairs touch each other; it's almost like you have no body space. So I try to sit in the back to back, where there's the 3 chairs, and [I] sort of sit in the middle and hope that nobody will sit on the other side of me. I know that sounds crazy but it's ... I know it's a small waiting area, if there was more space between the chairs I think it would be a little bit more comfortable. (Subject 24)

> Just the space. I just need a little bit more space—like when I'm waiting in the room I just switch that chair around a little bit so that none of my body touches that [of] another person. That that would help me. But other than that, I'm sort of quite comfortable—other than that. (Subject 24)

Engagement in care plans and choice. Participants were divided in terms of whether they believed they were actively involved in the management of their chronic conditions or whether they could disagree with their physician without harm to the relationship. When asked if she had the choice to follow or not follow recommendations from her physician, one participant indicated, "Yes. But I don't think I would have [voiced my opinion] until recently" (Subject 27). When asked if she had the right to disagree without it affecting the relationship another participant stated, "Depends on the subject because I don't know that it would be well received, to be honest" (Subject 29).

Some participants who were actively involved in decision making thought they had arrived at this level of involvement through their own activism and self-advocacy, rather than the explicit engagement of their physicians. Several participants articulated the belief that disagreements would be unwelcome. Some participants did not perceive their physicians to be open to their input and commentary. Physicians were perceived as lacking in time and lacking in attentiveness (eg, staring at computers, being "closed off"). However, others believed that whatever they wished to say would be heard by their physicians.

Trauma-informed care

Our discussions with participants about their primary care experiences and what they desired in their care revealed that some of the principles of trauma-informed care were being applied. Trauma-informed care involves the following 5 principles: trauma awareness and acknowledgment; safety and trustworthiness; choice, control, and collaboration; strengths-based and skills-building care; and cultural, historical, and gender issues (**Table 2**).[12-17]

Although physicians generally did not ask participants about their past trauma, participants themselves recognized that their adverse childhood experiences were important to their health and believed that their health care providers should be aware of their past (trauma awareness and acknowledgment principle). Participants' continuity of care fulfilled their desire to have their physicians "know" them as full human beings (safety and trustworthiness principle). Participants also recognized the humanity in their physicians. Participants identified physical procedures and examinations as a difficult element of care, so feeling safe with the physician was important. Most participants believed that they could question their physician's recommendations without threatening the patient-physician relationship (choice, control, and collaboration principle). There were participants who recognized that their physicians were not the only collaborators in their health and access to health care, but that the nurses and medical secretaries were as well (choice, control, and collaboration principle). This self-selected group of women reported active involvement in their care and decision making (choice, control, and collaboration principle). Several women explicitly articulated their ability to advocate for themselves—the lack of which they believed would be a barrier to high-quality health care for others (choice, control, and collaboration principle).

Discussion

Adverse childhood experiences are prevalent among the population attending primary care settings.[1] In addition, there is evidence to support that these patients have an increased overall burden of disease.[1] Our study suggests that they might be high users of health care services. Our participants reported having accessed the clinic an average of 12 times in the past year, which is higher than the average number of primary care visits for patients with chronic disease in Ontario (6.61 and 7.71 visits for those with 2 or 3 chronic diseases, respectively), and much higher than the overall Ontario average of 2.8 physician visits per year.[18,19] We propose that it is critical that family physicians inquire about the childhood experiences of their patients in the same way they ask about other risk factors for ill health (eg, family history, substance abuse, or poverty as recommended by the Ontario College of Family Physicians[20]). Evidence, both from our study and from others,[21] suggests that sensitive inquiry into ACEs does not upset patients or trigger any distress.

Understanding a patient's past experiences and exposure to traumatic events might improve the overall patient experience. It has been shown that using a trauma-informed approach might decrease use of health care resources. Follow-up work in the ACE study setting demonstrated that implementation of a trauma-informed past history questionnaire and having an acknowledgment of the findings by the primary care physician was associated with decreased repeat visits to the office and emergency department in the following year.[1]

Barriers to asking about patients' history with trauma need to be explored. In a study on domestic violence, physicians reported that they did not intervene or

discuss domestic abuse with patients owing to the lack of time, having inadequate training, feeling fearful of opening a Pandora's box or of offending the patient, and lacking the knowledge about available resources.[22,23]

In our study, participants explained that it was important that their health care providers know about their history with ACEs. They also stated that discussing their trauma did not trigger any feelings of distress. By learning about a patient's history with trauma, providers are incorporating one of the principles of trauma-informed care. Our findings revealed that our participants' primary care experiences did not always reflect these principles.

Trauma-informed care should be part of the primary care experience. Despite extensive awareness of the effects of trauma on the lives and health of women, it remains inadequately addressed by mainstream medicine.[5] Given the effect of ACEs on the prevalence of chronic diseases, it is essential to develop an approach to patients with a history of trauma. While the field of mental health and addictions has increasingly recognized trauma-informed care as the standard,[24] this is not the case in general practice and primary care. A 2002 Institute of Medicine report identified the inadequacy of health professional training with respect to family violence, and outlined the lack of resources, time, and energy devoted to improving this field.[5] Undergraduate and postgraduate medical education in Canada continues to do little to prepare incoming health professionals for the complexity of managing survivors of traumatic experiences.[25]

Limitations

A limitation of our study is its generalizability. The selection of the participants in the study has several biases. The participants were fairly homogeneous in terms of age. A different cohort—either male, or younger women—might produce different results. Participants also self-selected, so it is possible that they are not representative of all the women in the practice with ACEs and chronic disease, as these patients had to be sufficiently organized and motivated to contact the research assistant. In addition, some of the frustrations experienced by participants with respect to their health care were inherent in the nature of an academic setting. Certainly, our findings emphasize core principles of family medicine, such as the importance of continuity, and suggest that, even in the context of an academic practice, this should be emphasized as much as possible. This finding is of great concern, as patients' health care in the current environment is often fragmented with the use of walk-in clinics, multiple specialists, and learners in the system.

Finally, given the homogeneity of our participants who were all female and white, we did not actively elicit information that would have highlighted cultural, historical, or gender issues such as those that might be particularly noticeable in an Indigenous, gender-diverse, or immigrant population.

Conclusion

Our study, as well as our commentary on **page 170**, adds to the very small body of mostly gray literature beginning

Table 2. Principles of trauma-informed care

PRINCIPLE	APPLYING THE PRINCIPLE
Trauma awareness and acknowledgment	• Be aware of the prevalence and effect of trauma on substance use, and physical and mental health, and ensure that all staff members understand how trauma affects life's experiences
	• Recognize the effect of violence and abuse on a patient's development and coping strategies
	• Recognize the pervasiveness and long-term effects of violence and abuse
Safety and trustworthiness	• Help patients feel they are in a safe place
	• Recognize the need for physical and emotional safety
	• Avoid interventions that might trigger or retraumatize a patient
	• Design services that maximize access and participation by trauma survivors (including flexibility in scheduling)
	• Consider cultural competence with respect to a person's context (eg, financial instability) and life experiences
Choice, control, and collaboration	• Include patients in decisions affecting treatment
	• Develop a collaborative relationship
	• Involve service users when designing and evaluating services
Strengths-based and skills-building care	• Support a patient's empowerment
	• Highlight a patient's strengths and resilience rather than focusing on symptoms and pathology
Cultural, historical, and gender issues	• Incorporate processes that are sensitive to a patient's culture, ethnicity, and personal and social identity, as well as to his or her experience with trauma associated with group marginalization

to consider trauma-informed care in the primary care setting.[8] We propose that the health care system in general, and family medicine in particular, needs to become "trauma informed." The incorporation of the principles of trauma-informed care into the family medicine domain is an "intervention" we can offer. Bearing witness to a patient's worst secrets and offering acceptance can be empowering and healing. Universal trauma awareness and approaching patients with compassionate curiosity should become routine, as acknowledgment of ACEs might be therapeutic on its own. This new lens will enable physicians to respectfully acknowledge the challenges in patients' lives, to recognize the phenomenal resilience of so many, and to offer a place where patients feel safe, have trust in the providers, and are able to contribute to making choices in care. Finally, it would also allow physicians to engage in more empathic, holistic care with those patients who face ongoing challenges in terms of their physical and mental health.

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Contributors
All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests
None declared

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